U.S. Department of Labor

Office of Administrative Law Judges
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Issue date: 25Oct2002

Case No: 2001-BLA-1126

In the Matter of

HAROLD WAYNE HOWARD,
Claimant

v.

GREAT WESTERN COAL (KY) INC.,
Employer,

GREAT WESTERN RESOURCES,
Carrier,

and

DIRECTOR, OFFICE OF WORKERS' COMPENSATION PROGRAMS,
Party-in-Interest.

APPEARANCES:

Ron Carson
For the claimant

Greg Little, Esquire
For the employer/carrier

BEFORE: JOSEPH E. KANE
Administrative Law Judge

DECISION AND ORDER — AWARDING BENEFITS

This proceeding arises from a claim for benefits under Title IV of the Federal Coal Mine Health and Safety Act of 1969, as amended, 30 U.S.C. § 901 *et seq.* (the Act). Benefits are awarded to coal miners who are totally disabled due to pneumoconiosis. Surviving dependents of
coal miners whose deaths were caused by pneumoconiosis may also recover benefits. Pneumoconiosis, commonly known as black lung, is a chronic dust disease of the lungs arising from coal mine employment. 20 C.F.R. § 718.201(a) (2001).

On August 13, 2001, this case was referred to the Office of Administrative Law Judges for a formal hearing. (DX 40). Following proper notice to all parties, a hearing was held on August 12, 2002, in Harlan, Kentucky. The Director's exhibits were admitted into evidence pursuant to 20 C.F.R. § 725.456, and the parties had full opportunity to submit additional evidence.

The Findings of Fact and Conclusions of Law that follow are based upon my analysis of the entire record, arguments of the parties, and the applicable regulations, statutes, and case law. They also are based upon my observation of the demeanor of the witness who testified at the hearing. Although perhaps not specifically mentioned in this decision, each exhibit and argument of the parties has been carefully reviewed and thoughtfully considered. While the contents of certain medical evidence may appear inconsistent with the conclusions reached herein, the appraisal of such evidence has been conducted in conformance with the quality standards of the regulations.

The Act's implementing regulations are located in Title 20 of the Code of Federal Regulations, and section numbers cited in this decision exclusively pertain to that title. References to DX, CX, and EX refer to the exhibits of the Director, claimant, and employer, respectively. JX refers to the joint stipulation of medical evidence submitted by the parties. The transcript of the hearing is cited as "Tr." and by page number.

ISSUES

The following issues remain for resolution:

1. whether the miner has pneumoconiosis as defined by the Act and regulations;

2. whether the miner's pneumoconiosis arose out of coal mine employment;

3. whether the miner is totally disabled;

4. whether the miner's disability is due to pneumoconiosis; and

5. whether the evidence establishes a change in conditions or a mistake in a determination of fact within the meaning of Section 725.310.

FINDINGS OF FACT AND CONCLUSIONS OF LAW

Factual Background and Procedural History

The claimant, Harold Wayne Howard, was born on June 12, 1947. (DX 1). Mr. Howard married Carol Miller on October 10, 1969, and they reside together. *Id.* They had no children who were under eighteen or dependent upon them at this time this claim was filed. *Id.* Claimant graduated from high school and completed one year of electrical training at a vocational school. (Tr. 10). After high school, Claimant also served two years in the military. *Id.*

Claimant testified that he worked in the coal mine industry until 1995, but he began to experience breathing problems in the mid-1980s. (Tr. 13). He has treated with several physicians, and he now uses three inhalers four times per day. (Tr. 13-14). His breathing difficulties limit his activity, as he can participate in only light domestic chores such as grocery shopping. (Tr. 16). He is unable to mow his own lawn, and Claimant's respiratory difficulties forced him to abandon his hobbies of hunting and fishing. *Id.* In addition to his breathing difficulties, Claimant also suffers from pain in his knees and right rotator cuff. (Tr. 13).

Claimant smoked cigarettes for twelve to fifteen years, but he quit smoking over twenty years ago. (Tr. 24).

Mr. Howard filed his application for black lung benefits on May 20, 1999. (DX 1). The Office of Workers' Compensation Programs denied the claim on August 27, 1999, (DX 20). Claimant requested modification of the previous denial on August 1, 2000. (DX 26). The District Director issued a proposed denial of Claimant's modification request on September 20, 2000, and April 6, 2001. (DX 30, 37). Pursuant to claimant's request for a formal hearing, (DX 38), the case was transferred to the Office of Administrative Law Judges for a formal hearing. (DX 40).

Coal Mine Employment

The duration of a claimant's coal mine employment is relevant to the applicability of various statutory and regulatory presumptions. Claimant alleged twenty-three years of coal mine employment on his application for benefits. At the hearing, he testified that he had "almost twenty-five" years of coal mine employment. (Tr. 10). Finally, at the conference with the District Director, the parties stipulated to "at least" twenty-two years of coal mine employment. (DX 37). No party challenged the length of Claimant's coal mine employment when the case was transferred to the Office of Administrative Law Judges. (DX 40). Based upon my review of the record generally

and the Social Security records specifically, (DX 4), I accept the parties' stipulation in front of the District Director as accurate and credit claimant with twenty-two years of coal mine employment.

The great majority of Claimant's coal mine employment was spent working as an electrician. (Tr. 11; DX 2). His job required him to replace and repair electrical equipment inside and
outside the mine. (Tr. 11). Claimant testified that approximately 80% of his work was performed inside the mine, and he worked on various equipment such as washers, crusher stations, and power lines. (Tr. 11-12). His job required him to stoop, bend, and crawl. (Tr. 12; DX 6). Claimant estimated that he would crawl anywhere between thirty to three thousand feet. (DX 6). Claimant's job also required him to lift ten to twenty pound objects throughout his day and fifty to eighty pound objects two or three times per day. (Tr. 11; DX 6). His heaviest lifting occurred when he was required to change out a breaker panel on a substation ground. (Tr. 12). Claimant's job required not only heavy lifting but also carrying heavy objects over various distances, from thirty to one hundred feet. (DX 6).

For a brief period at the beginning of his work in the coal mine industry, Claimant worked as a coal washer in the preparation plant. (Tr. 12; DX 6).

Responsible Operator

In order to be deemed the responsible operator for this claim, Great Western Coal, Inc. must have been the last employer in the coal mining industry for which Claimant had his most recent period of coal mine employment of at least one year, including one day after December 31, 1969. 20 C.F.R. §§ 725.492(a), 493(a). The Social Security records and claimant's employment history forms establish that Great Western Coal, Inc. was the last employer to meet these conditions. (DX 2-4). Therefore, I find that Great Western Coal, Inc. properly is designated as the responsible operator.

On July 22, 2002, Employer filed a motion to dismiss itself as responsible operator, stating that, at the time Claimant ended his employment with Great Western Coal (KY), Inc., the company was not self-insured. Rather, Employer asserts that the proper carrier is ITT Hartford. The Director opposes the motion to dismiss.

Beyond mere allegation, the record is devoid of evidence of ITT's coverage of the employer. Indeed, upon the Director's search, no such coverage was located. (DX 21). Accordingly, the employer's motion to dismiss is denied.

Medical Evidence[1]

A. X-ray reports[2]

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 32	08/09/95	08/09/95	Baker/B/BCR	1/0 pneumoconiosis.
DX 32	09/01/95	09/19/95	Vaezy/B	1/1 pneumoconiosis.
DX 32	11/28/95	11/28/95	Vuskovich	1/0 pneumoconiosis.
DX 32	02/13/96	02/13/96	Harrison/B	0/1 profusion
DX 11	06/16/99	06/16/99	Wicker/B	Negative.
DX 13	06/16/99	07/09/99	Sargent/B/BCR	0/1 profusion.
DX 32	06/16/99	12/12/00	Wheeler/B	Negative.
DX 36	06/16/99	12/12/00	Scott/B	Completely negative.
DX 32	08/03/00	08/03/00	Westerfield/B	1/2 pneumoconiosis.

[1] The parties submitted a joint stipulation of medical evidence at the hearing of the instant case. (JX1; Tr. 7). Upon further review, I reject the parties' stipulation because it is rife with errors. For example, the stipulation of medical evidence references a December 12, 2000 x-ray interpretation by Dr. Baker. The document refers to the interpretation as "CX1." My review of the file has located no such interpretation. "CX1" is a pulmonary function test and not a chest x-ray interpretation. The record contains one x-ray interpretation by Dr. Baker, but the joint stip- ulation also references that document. The stipulation also records the presence of a September 15, 1995 pulmonary function test performed by Dr. Vaezy. (JX 1; DX 32). A thorough review of the record, however, reveals no such piece of evidence. Rather, it appears that the parties intended to denote the presence of Dr. Vaezy's September 19, 1995 pulmonary function test, but, in error, duplicated the results of the claimant's December 15, 1995 pulmonary function test. Furthermore, the stipulation credits with certain doctors performing tests incorrectly, such as the stipulation's recording Dr. Snow performing two pulmonary function tests when he performed only one. For these reasons, I do not accept the stipulation.

[2] A chest x-ray may indicate the presence or absence of pneumoconiosis. 20 C.F.R. §718.102 (a,b). It is not utilized to determine whether the miner is totally disabled, unless compli- cated pneumoconiosis is indicated wherein the miner may be presumed to be totally disabled due to the disease.

Exhibit	Date of X-ray	Date of Reading	Physician/ Qualifications	Interpretation
DX 35	12/01/00	12/01/00	Dahhan	Completely negative.
DX 33	12/07/00	12/08/00	Jarboe/B	0/1 profusion.

B. Pulmonary Function Studies[3]

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Tracings	Comments
DX 32 08/09/95	Baker	48 67.5"	1.24	2.54		0.49	None	Severe obstructive ventilatory defect.
DX 32 09/15/95	Vaezy	48 67.5"	1.46	2.97		0.49	Yes	
DX 32 11/28/95	Vuskovich	48 64"	1.56 1.86*	3.05 3.63*		0.51 0.51*	None	Good cooperation and comprehension. Moderate impairment, obstructive pattern.
DX 32 12/15/95	Vaezy	47 68"	1.62	3.08		0.53	None	Moderately severe impairment. Flow volume loop not obtained.
DX 32 02/13/96	Harrison	48 69"	1.84	3.37	75	0.55	Yes	Patient exhibited relatively poor effort.
DX 32 07/18/96	Vaezy	49 68"	1.89	3.34		0.57	None	Moderate obstructive impairment. No flow volume loop.

[3] The pulmonary function study, also referred to as a ventilatory study or spirometry, indicates the presence or absence of a respiratory or pulmonary impairment. 20 C.F.R. §718.104(c) . The regulations require that this study be conducted three times to assess whether the miner exerted optimal effort among trials, but the Board has held that a ventilatory study which is accompanied by only two tracings is in "substantial compliance" with the quality standards at § 718.204(c)(1). *Defore v. Alabama By-Products Corp.*, 12 B.L.R. 1-27 (1988). The values from the FEV1 as well as the MVV or FVC must be in the record, and the highest values from the trials are used to determine the level of the miner's disability.

Exhibit/ Date	Physician	Age/ Height	FEV_1	FVC	MVV	FEV_1/ FVC	Tracings	Comments
DX 32 06/08/99	Snow	51 68"	1.25 1.83*	2.51 3.38*	28	0.50 0.54*	Yes	Good effort.
DX 9 06/16/99	Wicker	52 68"	1.29 1.65*	3.05 3.34*	44 53*	0.42 0.49*	Yes	Good cooperation and comprehension.
DX 23 08/11/99	Wicker	52 68"	1.40	2.99	45	0.47	Yes	Good cooperation and comprehension.
DX 26 04/14/00	Craven	52 69"	1.27	2.54	27	0.50	Yes	Good effort and cooperation. Testing indicates severe obstruction and low vital capacity.
DX 32 08/03/00	Westerfield	53 67"	1.44 1.84*	2.89 3.42*	39 51*	0.50 0.54*	Yes	Good effort and cooperation. Moderate obstructive ventilatory dysfunction.
DX 35 12/01/00	Dahhan	53 68"	1.48 1.84*	2.45 2.77*	35 41*	0.60 0.66*	Yes	Fair cooperation and fair comprehension.
DX 33 12/07/00	Jarboe	53 68"	1.68 1.77*	2.98 3.54*	47 51*	0.56 0.50*	Yes	Reasonably good effort and cooperation. Moderate degree of airflow obstruction.
CX 3 10/25/01	Byrd	54 69"	1.68	3.20		0.53	No	Good effort and reproductability. Moderate to severe obstructive ventilatory defect.
CX 1 01/10/02	Narayanan	54 69"	1.52	2.77	127	0.55	Yes	Good effort and cooperation. Moderate obstruction and low vital capacity. Possible restrictive defect.

*denotes testing after administration of bronchodilator

Validation Studies:

On July 24, 1999, Dr. N. K. Burki, board-certified in internal medicine with a subspecialty in pulmonary medicine, issued a validation opinion of the claimant's June 16, 1999 pulmonary function study. (DX 10). Dr. Burki opined that the claimant's pulmonary function study was invalid because curve shapes on the tracings indicated suboptimal effort.

On September 11, 1999, Dr. Burki issued a validation opinion of the claimant's August 11, 1999 pulmonary function study. (DX 23). Again, Dr. Burki opined that the claimant's pulmonary function study was invalid because variability and curve shapes on the tracings indicated suboptimal effort.

On August 26, 2000, Dr. Burki issued a validation opinion of the claimant's April 14, 2000 pulmonary function study. (DX 28). Dr. Burki opined that the claimant's pulmonary function study was invalid because variability and curve shapes on the tracings indicated suboptimal effort.

On August 30, 2000, Dr. Bruce Broudy reviewed Claimant's April 14, 2000 pulmonary function test for validity. (DX 35). The doctor opined that the test was valid, except for the MVV measurement where the effort was poor. Dr. Broudy stated that the study showed a mixed defect with evidence of both obstruction and restriction.

On November 11, 2000, Dr. Burki issued numerous validation opinions of the claimant's pulmonary function studies. (DX 32). Dr. Burki opined that the claimant's August 9, 1995, September 19, 1995, February 13, 1996, and August 3, 2000 pulmonary function studies were valid. Dr. Burki opined, however, that the claimant's December 15, 1995 pulmonary function study was invalid because the study did not contain tracings. Dr. Burki also opined that the claimant's June 8, 1999 pulmonary function study was invalid due to slow paper speed.

C. Arterial Blood Gas Studies[4]

[4] Blood-gas studies are performed to detect an impairment in the process of alveolar gas exchange. This defect will manifest itself primarily as a fall in arterial oxygen tension either at rest or during exercise. 20 C.F.R. §718.105(a).

Exhibit	Date	Physician	pCO_2	pO_2	Resting/ Exercise	Comments
DX 32	08/09/95	Baker	46.7	61.1	Resting	Moderate resting arterial hypoxemia
DX 32	02/13/96	Harrison	38.0	85.0	Resting	
DX 11	06/16/99	Wicker	44.0 38.0	76.3 94.0	Resting Exercise	
DX 32	08/03/00	Westerfield	40.0	73.0	Resting	
DX 35	12/01/00	Dahhan	42.8 36.6	67.4 78.4	Resting Exercise	
DX 33	12/07/00	Jarboe	38.3	84.4	Resting	Moderate airflow obstruction

D. Narrative Medical Evidence

Dr. Abdul Dahhan examined the claimant on December 1, 2000. (DX 35). Dr. Dahhan recorded a twenty-five year coal mine employment history for the claimant. The doctor also noted that the claimant smoked one pack of cigarettes per day for twelve years but quit over two decades ago. From his examination, the doctor reported Claimant's complaints of frequent wheeze and dyspnea upon exertion such as climbing one flight of stairs. In addition to his physical examination, Dr. Dahhan submitted Claimant to an electrocardiogram, arterial blood gas study, pulmonary function testing, and a chest x-ray. The doctor recorded that the arterial blood gas revealed mild hypoxemia, and he concluded that the pulmonary function test demonstrated a partially reversible obstructive ventilatory defect with no evidence of a restrictive ventilatory abnormality or emphysema. Dr. Dahhan also reviewed other, previously produced medical evidence, including physician opinions and reports, chest x-rays, arterial blood gas studies, and pulmonary function studies. After his examination and evidence review, the doctor concluded that there was insufficient objective data to diagnose pneumoconiosis. Specifically, Dr. Dahhan based his diagnosis of no pneumoconiosis on the following evidence: 1) the obstructive abnormalities of Claimant's chest identified on examination, 2) the obstructive abnormality on pulmonary function studies with significant response to bronchodilator therapy, 3) the negative x-ray readings for pneumoconiosis, and 4) the alteration in Claimant's blood gas exchange mechanism that subsides with exercise. Although he did not diagnose pneumoconiosis, Dr. Dahhan diagnosed a partially reversible, moderately severe obstructive ventilatory defect based upon "various clinical and physiological assessments." *Id.* The doctor noted the lack of deterioration in Claimant's respiratory status, and he asserted that such a finding is seen with individuals with bronchial asthma and hyperactive airway disease. The doctor maintained that the claimant's

respiratory defect was not a byproduct of Claimant's coal mine employment because the waxing and waning severity of his respiratory disorder and its response to bronchodilator therapy was "inconsistent with the permanent adverse affects [sic] of coal dust on the respiratory system." *Id.* Dr. Dahhan concluded that Claimant's obstructive ventilatory defect was severe enough to render him unable to return to his previous coal mining work or a job of comparable physical demand.

Dr. Thomas M. Jarboe examined the claimant on December 7, 2000. (DX 35). In addition to his physical examination, Dr. Jarboe performed a complete pulmonary work-up and reviewed additional medical evidence generated by other physicians. The doctor recorded that Claimant worked twenty-five years in coal mine employment, primary as an electrician working above and underground. Dr. Jarboe noted that the claimant's current symptoms include wheeze, daily cough with occasional sputum production, shortness of breath, and dyspnea upon moderate exertion. Claimant explained that he had experienced these symptoms for the past ten to fifteen years. The doctor also recorded an approximately eighteen year smoking history of one to one and one-half packs per day ending twenty-two years ago. Dr. Jarboe reported that Claimant's pulmonary function test demonstrated a moderate degree of airflow obstruction which was partially reversible by bronchodilating agents. Dr. Jarboe also stated that Claimant's arterial blood gas study was normal and his carboxyhemoglobin test was that of a nonsmoker. After his examination and testing, the doctor diagnosed 1) bronchial asthma with an element of fixed airflow obstruction, 2) allergic rhinitis, 3) obesity, and 4) mild hypertension by history. Dr. Jarboe explained that there existed insufficient evidence to diagnose pneumoconiosis; while Claimant's x-ray showed a few opacities, they were not sufficient to make such a diagnosis. The doctor advanced that Claimant's pulmonary function tests exhibited no true restriction, and repeated measurements of the claimant's total lung capacity exhibited normal values and residual volumes have been significantly elevated. Dr. Jarboe also stated that Claimant's pulmonary function showed a marked increase after a dilating agents, which is not a characteristic of fixed, irreversible impairments such as coal workers' pneumoconiosis. The doctor diagnosed a moderately severe ventilatory impairment. Dr. Jarboe attributed Claimant's pulmonary functional abnormalities to bronchial asthma and smoking. The doctor opined that Claimant was totally and permanently disabled by a "long-standing, severe bronchial asthma and a past history of smoking cigarettes."

The record contains various pages of an opinion produced by Dr. Byron Westerfield, board-certified in internal medicine. (DX 32). The pages reveal that the doctor submitted a patient to an arterial blood gas study, chest x-ray, and a pulmonary function test. The doctor diagnosed coal workers' pneumoconiosis and chronic obstructive pulmonary disease. Dr. Westerfield also opined that the patient's disease and pulmonary impairment were both byproducts of coal dust exposure. The scattered pages, however, never reveal the patient's name, date, or occupation, nor do they record the findings of a physical examination.

Dr. Dahhan conducted a physical examination of the claimant on April 13, 1999. (DX 32). Dr. Dahhan noted Claimant's history of bronchial asthma and noted that the claimant never smoked. During the examination, Claimant complained of cough, wheezing, dyspnea upon exertion, orthopnea, sputum production, and chest tightness. In addition to his examination, Dr. Dahhan took a chest x-ray and noted that it showed hyper-inflated lungs. The doctor's final diagnosis was bronchial asthma.

Dr. Abdi Vaezy examined the claimant on September 19, 1995. (DX 32). During the examination, Claimant complained of shortness of breath, cough, and wheezing. When recording Claimant's medical, social and work histories, the doctor noted Claimant's twenty-three year coal mine employment history as an electrician and twelve year smoking history ending twelve years earlier. The doctor's report also highlighted Claimant's two prior hospitalizations for exacerbations of bronchitis. In addition to his physical examination, Dr. Vaezy submitted the claimant to a chest x-ray and pulmonary function test. In his report, Dr. Vaezy diagnosed 1) coal workers' pneumoconiosis based on Claimant's chest x-ray and coal dust exposure history and 2) asthmatic bronchitis based on "history." The doctor opined that the claimant's pneumoconiosis was related to his work environment, citing the twenty-three years of exposure to the environment. Dr. Vaezy also concluded that Claimant's pulmonary impairment was related to his work environment, in addition to his smoking history. The doctor stated that Claimant was unable, from a respiratory standpoint, to perform his usual coal mine work or comparable work based upon his severe obstructive impairment.

Dr. Glen Baker examined the claimant on August 9, 1995. (DX 32). The doctor's report acknowledged Claimant's twenty-three year coal mine employment history, twenty years of which were spent as an electrician. Dr. Baker noted that Claimant smoked one to one and one-half packs of cigarettes per day for ten to twelve years, but that Claimant has stopped smoking over one decade ago. During the examination, Claimant complained of shortness of breath, cough with sputum production, and wheezing. Claimant estimated that he could walk up to one-half mile on level ground if he walked slowly and was not rushed. In addition to his examination, Dr. Baker submitted Claimant to a chest x-ray, pulmonary function test, and arterial blood gas study. The

doctor diagnosed 1) coal workers' pneumoconiosis based on Claimant's x-ray and significant duration of coal dust exposure, 2) moderate resting arterial hypoxemia based on Claimant's

arterial blood gas study results, 3) chronic obstructive airway disease with a severe obstructive ventilatory defect based on pulmonary function testing, 4) chronic bronchitis based on Claimant's history, and 5) possible bronchial asthma based on history. Dr. Baker opined that Claimant's pneumoconiosis was caused by his coal mine employment and his pulmonary impairment was caused by his coal dust exposure, smoking history, and possibly bronchial asthma. Dr. Baker concluded that Claimant would have difficulty performing sustained manual labor, even in a dust-free environment, and, thus, he stated that Claimant was physically unable to perform his usual coal mine employment or comparable and gainful work.

On November 28, 1995, Dr. Matt Vuskovich examined Claimant. (DX 32). During the examination, Dr. Vuskovich noted that Claimant's chief complaints were exertional dyspnea and wheezing. The doctor recorded that Claimant denied chronic cough and chest pain. The doctor also noted an approximately twenty year, one and one-half pack per day smoking history and a twenty-three coal mine employment history. The doctor's report does not specify the type of coal mining work Claimant engaged in. Dr. Vuskovich submitted the claimant to a chest x-ray, pulmonary function test, and electrocardiogram. After his examination, the doctor diagnosed extrinsic asthma and simple coal workers' pneumoconiosis. The doctor's report does not state a basis for his diagnosis of pneumoconiosis. Dr. Vuskovich stated that the claimant's pneumoconiosis was caused by his work environment, but that any pulmonary impairment he suffered from was not caused by his work environment. The doctor stated, "Simple coal workers' pneumoconiosis does not cause asthma. Rarely does it cause any type of impairment. If there is impairment, it is a restrictive impairment." *Id.* Dr. Vuskovich opined that Claimant was not physically able, from a pulmonary standpoint, to perform his usual coal mine employment or comparable and gainful work. The doctor stated that it would be difficult for the claimant to perform any manual labor, but he also provided that the claimant had yet to reach maximum medical improvement.

Dr. Mitchell Wicker examined the claimant on June 16, 1999. (DX 11). For the claimant, Dr. Wicker recorded a twenty-three year coal mine employment history and a ten to twelve year smoking history ending nineteen years ago. The doctor noted Complainant's complaints of cough with daily sputum production, wheezing, and dyspnea upon any stress. During the examination, the doctor submitted Claimant to a chest x-ray, pulmonary function study, arterial blood gas, and electrocardiogram. Dr. Wicker opined that Claimant did not suffer from pneumoconiosis, but he did not explicitly state the bases for his opinion. The doctor also concluded that Claimant lacked the ability to perform his previous occupation in the coal mine as a result of his "previous cigarette abuse." *Id.* The bases for the doctor's impairment opinion were Claimant's pulmonary function test results. Dr. Wicker ranked the claimant's impairment level as "severe."

Modification

Section 725.310 provides that a claimant, employer, or the district director may file a petition for modification within one year of the filing of the last denial of benefits. Modification petitions may be based upon a change in condition or a mistake in a determination of fact. 20 C.F.R. § 725.310(a). On August 1, 2000, (DX 26), Claimant timely requested modification of the denial dated August 27, 1999. (DX 20).

In deciding whether claimant has established a change in condition, I must "perform an independent assessment of the newly submitted evidence, in conjunction with evidence previously submitted, to determine if the weight of the new evidence is sufficient to establish the element or elements which defeated entitlement." *Napier v. Director, OWCP*, 17 BLR 1-111, 1-113 (1993). *See also Nataloni v. Director, OWCP*, 17 BLR 1-82, 1-84 (1993). The circuit courts and Benefits Review Board have held that, for purposes of establishing modification, the phrase "change in conditions" refers to a change in the claimant's physical condition. *See General Dynamics Corp. v. Director, OWCP*, 673 F.2d 23 (1st Cir. 1982); *Director, OWCP v. Drummond Coal Co.*, 831 F.2d 240 (11th Cir. 1987); *Lukman v. Director, OWCP*, 11 B.L.R. 1-71 (1988) (*Lukman II*). *See, e.g., Amax Coal Co. v. Franklin*, 957 F.2d 355 (7th Cir. 1992) (letter from miner's physician indicating that the miner may have black lung disease did not establish a "change in conditions," but was sufficient to warrant reopening the claim based upon a "mistake in a determination of fact").

In deciding whether the prior decision contains a mistake in a determination of fact, I must review all the evidence of record, including evidence submitted since the most recent denial. New evidence, however, is not a prerequisite to modification based upon a mistake of fact. *Nataloni*, 17 BLR at 1-84; *Kovac v. BCNR Mining Corp.*, 14 BLR 1-156, 1-158(1990), *aff'd on recon.* 16 BLR 1-71, 1-73 (1992). Rather, the factfinder is vested "with broad discretion to correct mistakes of fact, whether demonstrated by wholly new evidence, cumulative evidence, or merely further reflection on the evidence initially submitted." *O'Keefe v. Aerojet-General Shipyards, Inc.*, 404 U.S. 254, 257 (1971).

In the prior denial, the District Director determined that Claimant did not have pneumoconiosis or any totally disabling respiratory or pulmonary disease arising from coal mine employment. The evidence submitted since this decision includes chest x-rays, examination reports, pulmonary function studies, and arterial blood gas studies. Therefore, I will consider whether this evidence, in conjunction with the previously submitted evidence, establishes entitlement to benefits.

DISCUSSION AND APPLICABLE LAW

Because Mr. Howard filed his application for benefits after March 31, 1980, this claim shall be adjudicated under the regulations at 20 C.F.R. Part 718. Under this part of the regulations, claimant must establish by a preponderance of the evidence that he has pneumoconiosis, that his pneumoconiosis arose from coal mine employment, that he is totally disabled, and that his total disability is due to pneumoconiosis. Failure to establish any of these elements precludes entitlement to benefits. *See Anderson v. Valley Camp of Utah, Inc.*, 12 BLR 1-111, 1-112 (1989).

Upon my review of the evidence as it existed at the time of the prior denial, I have found no mistake of fact. Therefore, I will review the newly-submitted evidence to determine if it supports entitlement to benefits. My initial review is limited to the newly-submitted evidence. *See Napier*, 17 BLR at 1-113 (1993).

Pneumoconiosis and Causation

The new regulatory provisions at 20 C.F.R. § 718.201 contain a modified definition of "pneumoconiosis" and they provide the following:

(a) For the purposes of the Act, 'pneumoconiosis' means a chronic dust disease of the lung and its sequelae, including respiratory and pulmonary impairments, arising out of coal mine employment. This definition includes both medical, or 'clinical', pneumoconiosis and statutory, or 'legal', pneumoconiosis.

(1) Clinical Pneumoconiosis. 'Clinical pneumoconiosis' consists of those diseases recognized by the medical community as pneumoconioses, *i.e.*, the conditions characterized by permanent deposition of substantial amounts of particulate matter in the lungs and the fibrotic reaction of the lung tissue to that deposition caused by dust exposure in coal mine employment. This definition includes, but is not limited to, coal workers' pneumoconiosis, anthracosilicosis, anthracosis, anthrosilicosis, massive pulmonary fibrosis, silicosis or silicotuberculosis, arising out of coal mine employment.

(2) Legal Pneumoconiosis. 'Legal pneumoconiosis' includes any chronic lung disease or impairment and its sequelae arising out of coal mine employment. This definition includes, but is not limited to, any chronic restrictive or obstructive pulmonary disease arising out of coal mine employment.

(b) For purposes of this section, a disease 'arising out of coal mine employment' includes any chronic pulmonary disease or respiratory or pulmonary impairment significantly related to, or substantially aggravated by, dust exposure in coal mine employment.

(c) For purposes of this definition, 'pneumoconiosis' is recognized as a latent and progressive disease which may first become detectable only after the cessation of coal mine dust exposure.

20 C.F.R. § 718.201 (Dec. 20, 2000). Section 718.202(a) provides four methods for determining the existence of pneumoconiosis. Each shall be addressed in turn.

Under section 718.202(a)(1), a finding of pneumoconiosis may be based upon x-ray evidence. Because pneumoconiosis is a progressive disease, I may properly accord greater weight to the interpretations of the most recent x-rays, especially where a significant amount of time separates the newer from the older x-rays. *Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc); *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). As noted above, I also may assign heightened weight to the interpretations by physicians with superior radiological qualifications. *See McMath v. Director, OWCP*, 12 BLR 1-6 (1988); *Clark*, 12 BLR 1-149 (1989).

The newly-submitted evidence contains nine interpretations of eight chest x-rays. Of these interpretations, five were negative for pneumoconiosis while four were positive for the disease. Analyzing each x-ray separately, the newly-submitted evidence contains four "negative" x-rays and four "positive" x-rays.[5] Four "B" readers produced negative interpretations, whereas three "B" readers produced positive interpretations. One of the "B" readers producing a positive interpretation, Dr. Baker, was a dually-qualified physician.

I find the newly-submitted chest x-ray evidence is in equipoise. Four x-rays produced positive interpretations and four x-rays produced negative interpretations. I accord Dr. Baker's positive interpretation additional weight because of his status as a dually-qualified physician, but that additional weight only matches and does not counter-balance the probative value I accord the additional "B" reader issuing a negative interpretation. Thus, as it is Claimant's burden to demonstrate a change in conditions by a preponderance of the evidence, I find Claimant has failed to meet his burden. The newly-submitted evidence does not demonstrate the presence of pneumoconiosis by a preponderance of the evidence.

Under Section 718.202(a)(2), a claimant may establish pneumoconiosis through biopsy
or autopsy evidence. This section is inapplicable herein because the record contains no such evidence.

Under Section 718.202(a)(3), a claimant may prove the existence of pneumoconiosis if one of the presumptions at Sections 718.304 to 718.306 applies. Section 718.304 requires x-ray, biopsy, or equivalent evidence of complicated pneumoconiosis. Because the record contains no such evidence, this presumption is unavailable. The presumptions at Sections 718.305 and 718.306 are inapplicable because they only apply to claims that were filed before January 1, 1982, and June 30, 1982, respectively. Because none of the above presumptions

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[5] This balance is struck because the June 16, 1999 x-ray produced two negative interpretations. (DX 32, 36).

applies to this claim, claimant has not established pneumoconiosis pursuant to Section 718.202(a)(3).

Section 718.202(a)(4) provides the fourth and final way for a claimant to prove that he has pneumoconiosis. Under section 718.202(a)(4), a claimant may establish the existence of the disease if a physician exercising reasoned medical judgment, notwithstanding a negative x-ray, finds that he suffers from pneumoconiosis. Although the x-ray evidence is negative for pneumoconiosis, a physician's reasoned opinion may support the presence of the disease if it is supported by adequate rationale besides a positive x-ray interpretation. *See Trumbo v. Reading Anthracite Co.*, 17 BLR 1-85, 1-89 (1993); *Taylor v. Director, OWCP*, 1-22, 1-24 (1986). The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions.

A "documented" opinion is one that sets forth the clinical findings, observations, facts and other data on which the physician based the diagnosis. *Fields v. Island Creek Coal Co.*, 10 BLR 1-19 (1987); *Fuller v. Gibraltar Coal Corp.*, 6 BLR 1-1291 (1984). A report may be adequately documented if it is based on items such as a physical examination, symptoms and patient's history. *See Hoffman v. B & G Construction Co.*, 8 BLR 1-65 (1985); *Hess v. Clinchfield Coal Co.*, 7 BLR 1-295 (1984); *Buffalo v. Director*, OWCP, 6 BLR 1-1164, 1-1166 (1984); *Gomola v. Manor Mining and Contracting Corp.*, 2 BLR 1-130 (1979).

A "reasoned" opinion is one in which the underlying documentation and data are adequate to support the physician's conclusions. *See Fields, supra*. The determination that a medical opinion is "reasoned" and "documented" is for this Court to determine. *See Clark v. Karst-Robbins Coal Co.*, 12 B.L.R. 1-149 (1989)(en banc). An unsupported medical conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984). *See also Phillips v. Director, OWCP*, 768 F.2d 982 (8th Cir. 1985); *Smith v. Eastern Coal Co.*, 6 B.L.R. 1-1130 (1984); *Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983) (a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis); *Waxman v. Pittsburgh & Midway Coal Co.*, 4 B.L.R. 1-601 (1982).

Dr. Dahhan opined that Claimant did not suffer from pneumoconiosis. I accord Dr. Dahhan's opinion less weight, however, as I find it poorly reasoned. While the doctor's opinion is well documented and his diagnosis states explicit bases for his opinion regarding the presence of

pneumoconiosis, Dr. Dahhan fails to discuss the numerous positive chest x-ray interpretations present in his medical evidence review. My review of the doctor's opinion reveals that the medical evidence Dr. Dahhan reviewed contained four positive interpretations and five negative interpretations. Dr. Dahhan's failure to discuss this evidence contrary to his ultimate conclusion renders his opinion less probative. Accordingly, I grant the doctor's opinion less probative weight.

Dr. Jarboe's opinion suffers from a similar flaw. Dr. Jarboe opined that Claimant did not suffer from pneumoconiosis based upon the doctor's negative x-ray interpretation, Claimant's past history, and "normal," non-restrictive pulmonary function tests. While the doctor's opinion is well documented, the doctor's opinion is poorly reasoned as Dr. Jarboe fails to address the numerous positive chest x-ray interpretations he possessed. The doctor's recitation of the medical evidence he reviewed accounted five x-rays interpretations – four of which were positive for pneumoconiosis. Dr. Jarboe's failure to address such evidence renders his opinion less probative, and I accord his opinion less weight.

I grant Dr. Westerfield's opinion no weight because only random pages of his opinion are found in the record. Indeed, Claimant's name is not found on a single page.

Dr. Dahhan's one page, April 13, 1999 opinion does not address the presence or absence of pneumoconiosis. Accordingly, I grant his opinion no weight.

Dr. Vaezy diagnosed coal workers' pneumoconiosis and asthmatic bronchitis. Both diagnoses qualify as positive findings of pneumoconiosis under the regulations. *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). I shall address each separately.

Because the doctor's diagnosis of coal workers' pneumoconiosis was based upon Claimant's chest x-ray and coal dust exposure history alone, I grant his opinion little weight. In *Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000), the Sixth Circuit Court of Appeals intimated that such bases alone do not constitute "sound" medical judgment under section 718.202(a)(4). *Id.* at 576.The Benefits Review Board has also held permissible the discrediting of physician opinions amounting to no more than x-ray reading restatements. *See Worhach v. Director, OWCP*, 17 B.L.R. 1-105, 1-110 (1993)(citing *Anderson v. Valley Camp of Utah, Inc.*, 12 B.L.R. 1-111, 1-113(1989), and *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405 (1985)). In *Taylor*, the Benefits Review Board explained that the fact that a miner worked for a certain period of time in the coal mines alone "does not tend to establish that he does not have any respiratory disease arising out of coal mine employment." *Taylor*, 8 B.L.R. at 1-407. The Board went on to state that, when a doctor relies solely on a chest x-ray and a coal dust exposure history, a doctor's failure to explain how the duration of a miner's coal mine employment supports his diagnosis of the presence

or absence of pneumoconiosis renders his or her opinion "merely a reading of an x-ray...and not a reasoned medical opinion." *Id.* Dr. Vaezy's opinion provides no other bases for his diagnosis of pneumoconiosis other than Claimant's x-ray and coal dust exposure history. Because of this, I grant the doctor's opinion little weight.

I also grant less weight to the doctor's diagnosis of asthmatic bronchitis because the doctor's stated basis of "history" is vague. It is unclear whether the doctor is referring to the Claimant social, medical, or occupational history. An opinion may be given little weight if it is

equivocal or vague. *Island Creek Coal Co. v. Holdman*, 202 F.3d 873 (6th Cir. 2000). Thus, I accord the doctor's opinion less weight.

Dr. Baker diagnosed coal workers' pneumoconiosis, chronic obstructive airway disease, chronic bronchitis, and "possible" bronchial asthma. If demonstrated, each of the doctor's diagnoses constitutes clinical or legal pneumoconiosis under the applicable regulations. *See* 20 C.F.R. §718.201(a)(1-2); *Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983); *see also Warth v. Southern Ohio Coal Co.*, 60 F.3d 173 (4th Cir. 1995)(holding that chronic obstructive lung disease is encompassed in the legal definition of pneumoconiosis). I shall address each of the doctor's diagnoses separately.

I grant little weight to the doctor's diagnosis of coal workers' pneumoconiosis for reasons identical to my discrediting of Dr.Vaezy's opinion. Dr. Baker relies solely on Claimant's x-ray and coal dust exposure history as the bases of his positive pneumoconiosis diagnosis – rendering his opinion little more than an x-ray reading restatement. *Taylor v. Brown Badgett, Inc.*, 8 B.L.R. 1-405, 1-407 (1985). Accordingly, I grant his opinion no weight.

The doctor's diagnosis of chronic obstructive airway disease is based upon Claimant's pulmonary function testing. I find this opinion well reasoned and well diagnosed. Thus, I grant the doctor's opinion on this point probative value.

Dr. Baker's latter two diagnoses, chronic bronchitis and "possible" bronchial asthma, are based upon Claimant's "history." As above with Dr. Vaezy's opinion, I grant less weight to the Dr. Baker's diagnoses because a basis of "history" is vague. It is unclear whether the doctor is referring to the Claimant's social, medical, or occupational histories. An opinion may be given little weight if it is equivocal or vague. *Island Creek Coal Co.*, 202 F.3d at 873. Thus, I accord the doctor's opinion less weight concerning these diagnoses. Furthermore, Dr. Baker's diagnosis of "possible" bronchial asthma is equivocal, further eroding any probative value in his opinion. *Id.*

I find Dr. Vuskovich's diagnosis of pneumoconiosis poorly reasoned. The doctor fails to state the basis (or bases) of his positive diagnosis of pneumoconiosis. An unsupported medical

conclusion is not a reasoned diagnosis. *Fuller v. Gibraltar Corp.*, 6 B.L.R. 1-1292 (1984). *See also Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(holding a report is properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis). Because the doctor's opinion is poorly reasoned, I grant it less weight.

Dr. Vuskovich also diagnosed extrinsic asthma based upon Claimant's pulmonary function testing and medical history of asthma. Asthma, asthmatic bronchitis, or emphysema

may fall under the regulatory definition of pneumoconiosis *if they are related to coal dust exposure*. *See Robinson v. Director, OWCP*, 3 B.L.R. 1-798.7 (1981); *Tokarcik v. Consolidation Coal Co.*, 6 B.L.R. 1-666 (1983). The doctor's report, however, does not address the etiology of Claimant's asthma. Thus, while the doctor's diagnosis of asthma can constitute legal pneumoconiosis under the regulations, I grant the doctor's diagnosis less weight as it fails to ascribe an etiology to the claimant's asthma.

I find Dr. Wicker's negative diagnosis of pneumoconiosis poorly reasoned, and I, concomitantly, grant the doctor's opinion less weight. Dr. Wicker fails to state the basis (or bases) for his determination that the claimant does not suffer from pneumoconiosis, and, thus, his opinion is less probative on the issue. I do, however, find the doctor's opinion to be well documented.

Upon a further review of the narrative medical evidence addressing the presence or absence of pneumoconiosis, I find that the newly submitted evidence demonstrates the presence
of pneumoconiosis by a preponderance of the evidence. First, several of the physician opinions weigh neither for or against a finding of pneumoconiosis. I have granted no weight to opinions submitted from Drs. Westerfield, Dahhan, Vaezy, Baker, and Vuskovich. However, Drs. Dahhan, Vaezy, Baker, and Vuskovich also have opinions in the record to which I have ascribed probative value. Of the opinions receiving probative value on the issue of the presence or absence of pneumoconiosis, no opinion of record is free from analytical flaws, beyond Dr. Baker's diagnosis of chronic obstructive airway disease. However, when I compare the sum of the evidence, I find that a preponderance of the evidence demonstrates pneumoconiosis. Simply put, the limited probative values of the opinions of Drs. Vaezy, Baker, and Vuskovich outweigh the limited probative values of the opinions of Drs. Dahhan and Jarboe.

Claimant's demonstration of pneumoconiosis by a preponderance of the evidence also demonstrates a "change in conditions." Accordingly, Claimant is now entitled to a full review of the record to determine his entitlement to benefits. I shall reevaluate the x-ray and narrative evidence, including previously submitted evidence.

My analysis of the x-ray evidence does not change when I consider the previously submitted x-ray interpretations, as only two negative interpretations are added to my analysis.

Accordingly, Claimant still fails to demonstrate pneumoconiosis by a preponderance of the evidence under section 718.202(a)(1).

Section 718.202(a)(2,3) are also inapplicable to the previously submitted evidence.

The previously submitted medical evidence contained one narrative medical opinion from Dr. Wicker. The doctor opined that Claimant did not suffer from pneumoconiosis, but I

found the doctor's opinion not well reasoned. The limited probative value of Dr. Wicker's opinion, how-ever, does not change my previous analysis. Reviewing the evidence, I am confronted with three physician opinions diagnosing pneumoconiosis (Drs. Vaezy, Baker, and Vuskovich) and three physicians opining that Claimant does not suffer from pneumoconiosis. (Drs. Dahhan, Jarboe, and Wicker). Each of the physicians produced opinions I found to be unworthy of full probative weight in some fashion. I did not discredit, however, Dr. Baker's well reasoned and well documented diagnosis of chronic obstructive airway disease. The probative value I ascribe to Dr. Baker's positive diagnosis tips the scales in favor of a positive finding of pneumoconiosis. Accordingly, I find that Claimant has demonstrated pneumoconiosis by a preponderance of the evidence under section 718.202(a)(4).

Because Mr. Howard has established over ten years of coal mine employment, he is entitled to a rebuttable presumption that his pneumoconiosis arose from coal mine employment. *See* 20 C.F.R. § 718.203(b). This presumption may be rebutted by evidence demonstrating another cause for claimant's pneumoconiosis.

The record contains evidence of a smoking history, but I find such evidence insufficient to rebut the presumption of etiology. The evidence addressing Claimant's smoking is uniform in its provision that Claimant stopped smoking approximately two decades ago. Furthermore, no physician's opinion attributed Claimant's pulmonary disease to smoking. Drs. Jarboe, Baker, and Vaezy all listed smoking as a contributing factor to Claimant's pulmonary impairment, but they did not attribute any disease to smoking. Accordingly, I find that Claimant's pneumoconiosis arose from coal mine employment.

In sum, the evidence establishes that Claimant has pneumoconiosis and that his pneumoconiosis arose out of coal mine employment. In order to establish entitlement to benefits, however, the evidence also must establish that claimant is totally disabled due to pneumoconiosis.

Total Disability Due to Pneumoconiosis

A miner is considered totally disabled when his pulmonary or respiratory condition prevents him from performing his usual coal mine work or comparable work. 20 C.F.R. § 718.204

(b)(1). Non-respiratory and non-pulmonary impairments have no bearing on a finding of total disability. *See Beatty v. Danri Corp.*, 16 BLR 1-11, 1-15 (1991). Section 718.204(b)(2) provides several criteria for establishing total disability. Under this section, I must first evaluate the evidence under each subsection and then weigh all of the probative evidence together, both like and unlike evidence, to determine whether claimant has established total respiratory disability by a preponderance of the evidence. *Shedlock v. Bethlehem Mines Corp.*, 9 BLR 1-195, 1-198 (1987).

Under Sections 718.204(b)(2)(i) and (b)(2)(ii), total disability may be established with qualifying pulmonary function studies or arterial blood gas studies.[6]

All ventilatory studies of record, both pre-bronchodilator and post- bronchodilator, must be weighed. *Strako v. Ziegler Coal Co.*, 3 B.L.R. 1-136 (1981). To be qualifying, the FEV_1 as well as the MVV or FVC values must equal or fall below the applicable table values. *Tischler v. Director, OWCP*, 6 B.L.R. 1-1086 (1984). I must determine the reliability of a study based upon its conformity to the applicable quality standards, *Robinette v. Director, OWCP*, 9 B.L.R. 1- 154 (1986), and must consider medical opinions of record regarding reliability of a particular study. *Casella v. Kaiser Steel Corp.*, 9 B.L.R. 1-131 (1986). In assessing the reliability of a study, I may accord greater weight to the opinion of a physician who reviewed the tracings. *Street v. Consolidation Coal Co.*, 7 B.L.R. 1-65 (1984). If a study is accompanied by three tracings, then I may presume that the study conforms unless the party challenging conformance submits a medical opinion in support thereof. *Inman v. Peabody Coal Co.*, 6 B.L.R. 1-1249 (1984). Also, little or no weight may be accorded to a ventilatory study where the miner exhibited "poor" cooperation or comprehension. *Houchin v. Old Ben Coal Co.*, 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984); *Justice v. Jewell Ridge Coal Co.*, 3 B.L.R. 1-547 (1981).

The August 9, 1995, November 28, 1995, December 15, 1995, July18, 1996, and October 25, 2001 pulmonary function tests do not contain tracings. Because tracings are used to determine the reliability of a ventilatory study, a study which is not accompanied by three tracings may be discredited. *Estes v. Director, OWCP*, 7 B.L.R. 1-414 (1984). Accordingly, I will not consider the specified studies as they are invalid.

The record also contains studies invalidating the June 8, 1999, June 16, 1999, August 11, 1999, and April 14, 2000 pulmonary function tests. The studies invalidating the pulmonary function tests provide detailed reasoning for such invalidation, and I grant the invalidating studies probative value. In addition, I grant additional weight to Dr. Burki's invalidation studies due to his credentials. The specificity of Dr. Burki's reports and his credentials lead me to grant his interpretation of the studies more weight than the physicians initially interpreting the results. Accordingly, I find the June 8, 1999, June 16, 1999, August 11, 1999, and April 14, 2000 pulmonary function tests invalid, and I will not consider them in my total disability analysis.

Dr. Harrison's February 13, 1996 pulmonary function test report stated that Claimant exhibited "relatively poor effort." As the doctor's report is equivocal on the degree of poor effort, I do not strip the test of any probative value, but I grant it limited probative weight.

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[6]A "qualifying" pulmonary function study or arterial blood gas study yields values that are equal to or less than the applicable table values found in Appendices B and C of Part 718. *See* 20 C.F.R. § 718.204(b)(2)(i) and (ii). A "non-qualifying" test produces results that exceed the table values.

Houchin v. Old Ben Coal Co., 6 B.L.R. 1-1141 (1984); *Runco v. Director, OWCP*, 6 B.L.R. 1-945 (1984); *Justice v. Jewell Ridge Coal Co.*, 3 B.L.R. 1-547 (1981).

In the pulmonary function studies of record, there is a discrepancy in the height attributed to the claimant. The fact-finder must resolve conflicting heights of the miner recorded on the ventilatory study reports in the claim. *Protopappas v. Director, OWCP*, 6 B.L.R. 1- 221 (1983). *See also Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995). I find the miner's height to be the average of the reported heights in the valid studies, or 68.08 inches.

The September 15, 1995 pulmonary function test produced qualifying FEV_1 and FEV_1/FVC values. The February 13, 1996 test produced qualifying FEV_1 and FEV_1/FVC values. Both pre- and post-bronchodilator tests on August 3, 2000, produced qualifying FEV_1 and FEV_1/FVC values. The pre-bronchodilator test on December 1, 2000 produced qualifying FEV_1 and FVC values. The post-bronchodilator test on December 7, 2000 produced qualifying FEV_1 and FEV_1/FVC values. The January 10, 2002 pulmonary function test produced qualifying FEV_1 and FEV_1/FVC values. These tests all produced qualifying, valid results, and I accord them probative weight as evidence of total disability.

All blood gas study evidence of record must be weighed. *Sturnick v. Consolidation Coal Co.*, 2 B.L.R. 1-972 (1980). This includes testing conducted before and after exercise. *Coen v. Director, OWCP*, 7 B.L.R. 1-30 (1984); *Lesser v. C.F. & I. Steel Corp.*, 3 B.L.R. 1-63 (1981). In order to render a blood gas study unreliable, the party must submit a medical opinion that a condition suffered by the miner, or circumstances surrounding the testing, affected the results of the study and, therefore, rendered it unreliable. *Vivian v. Director, OWCP*, 7 B.L.R. 1-360 (1984) (miner suffered from several blood diseases); *Cardwell v. Circle B Coal Co.*, 6 B.L.R. 1-788 (1984) (miner was intoxicated). Similarly, in *Big Horn Coal Co. v. Director, OWCP [Alley]*, 897 F.2d 1045 (10th Cir. 1990) and *Twin Pines Coal Co. v. U.S. DOL*, 854 F.2d 1212 (10th Cir. 1988), the court held that the administrative law judge must consider a physician's report which addresses the reliability and probative value of testing wherein he or she attributes qualifying results to non- respiratory factors such as age, altitude, or obesity.

The record contains no qualifying arterial blood gas studies. I find the studies valid, and I accord them probative weight as evidence of no total disability.

Section 718.204(b)(2)(iii) provides that a claimant may prove total disability through evidence establishing cor pulmonale with right-sided congestive heart failure. This section is inapplicable to this claim because the record contains no such evidence.

Where a claimant cannot establish total disability under subparagraphs (b)(2)(i), (ii), or (iii), Section 718.204(b)(2)(iv) provides another means to prove total disability. Under this section, total disability may be established if a physician exercising reasoned medical

judgment, based on medically acceptable clinical and laboratory diagnostic techniques, concludes that a respiratory or pulmonary impairment prevents the miner from engaging in his usual coal mine work or comparable and gainful work. The weight given to each medical opinion will be in proportion to its documented and well-reasoned conclusions.

In assessing total disability under § 718.204(c)(4), the administrative law judge, as the fact-finder, is required to compare the exertional requirements of the claimant's usual coal mine employment with a physician's assessment of the claimant's respiratory impairment. *Cornett v. Benham Coal, Inc.*, 227 F.3d 569, Case No. 99-3469 (6th Cir. 2000) (a finding of total disability may be made by a physician who compares the exertional requirements of the miner's usual coal mine employment against his physical limitations); *Schetroma v. Director, OWCP*, 18 B.L.R. 1-19 (1993) (a qualified opinion regarding the miner's disability may be given less weight). *See also Scott v. Mason Coal Co.*, 14 B.L.R. 1-37 (1990)(en banc on recon.). Once it is demonstrated that the miner is unable to perform his or her usual coal mine work, a prima facie finding of total disability is made and the party opposing entitlement bears the burden of going forth with evidence to demonstrate that the miner is able to perform "comparable and gainful work" pursuant to § 718.204(c)(2). *Taylor v. Evans & Gambrel Co.*, 12 B.L.R. 1-83 (1988).

Every physician addressing Claimant's impairment level opined that Claimant was unable, from a respiratory standpoint, to perform his usual coal mine employment or comparable, gainful work.

Dr. Dahhan's opinion is poorly reasoned, and therefore, accord it less probative weight. The doctor states that the claimant's "partially reversible moderate severe obstructive ventilatory defect" is demonstrated by "various clinical and physiological assessments." (DX 35). The doctor's failure to delve beyond the generic when explaining the bases for his opinion renders his opinion less probative. Furthermore, Dr. Dahhan fails to provide a discussion of the exertional requirements of Claimant's coal mine employment. This failure renders his opinion less probative as the omission prohibits this Court from determining if Dr. Dahhan properly considered the

interplay between the exertional requirements of Claimant's usual coal mine employment and his physiological limitations. Accordingly, I grant the doctor's opinion less weight.

I also find Dr. Jarboe's opinion less probative on the issue of impairment. The doctor fails to state the bases for his conclusion of total disability, although his conclusion includes his opinion as to the etiology of Claimant's impairment. In addition, the doctor fails to demonstrate his understanding of the tension between the exertional requirements of Claimant's usual coal mine employment and his physiological limitations. Because of the doctor's failure to explain his medical conclusions, I find his opinion poorly reasoned and grant it less weight. *See Duke v. Director, OWCP*, 6 B.L.R. 1-673 (1983)(holding a report is

properly discredited where the physician does not explain how underlying documentation supports his or her diagnosis).

Dr. Westerfield's opinion does not include a discussion of Claimant's impairment level, and, thus, it weighs neither in favor nor against a finding of total disability.

Likewise, Dr. Dahhan's April 13, 1999 opinion does not address Claimant's impairment level, and I grant it no probative value.

Dr. Vaezy's diagnosis of total disability, based on Claimant's September 15, 1995 pulmonary function test is well reasoned and well documented. The doctor also addresses the impact of Claimant's pulmonary dysfunction on his ability to physically exert himself. Accordingly, I grant the doctor's opinion probative weight.

Dr. Baker's opinion is well reasoned and well documented, and I grant it probative weight on the issue of Claimant's impairment level. The doctor provides the bases for his medical conclusion, and he sufficiently addresses the tension between Claimant's physiological capabilities and the exertional requirements of his usual coal mine employment.

Dr. Vuskovich does not explicitly state the rationale behind his conclusion that Claimant is totally disabled, and, thus, I grant his opinion less weight. The doctor merely states, "At this level
of impairment, it would be difficult to do any type of manual labor." (DX 32). Thus, while the report addresses the claimant's physiological capabilities, it does not demonstrate upon what bases the doctor relied to determine Claimant's "impairment." Accordingly, I grant the opinion less weight.

Dr. Wicker's opinion is well reasoned and well documented. Dr. Wicker opined that Claimant was unable to perform his usual coal mine employment based upon Claimant's pulmonary function test. However, I grant the doctor's opinion less weight due to his failure to demonstrate an understanding of the exertional requirements of Claimant's coal mine employment.

When I consider all of the evidence addressing Claimant's impairment level, I find that Claimant has demonstrated total disability by a preponderance of the evidence. A majority of the valid pulmonary function tests and each of the narrative medical opinions weigh in favor of a positive finding of total disability. When I compare the combined probative weight of the pulmonary function tests and narrative medical opinions against the non-qualifying arterial blood gas studies, I find the preponderance of the evidence demonstrates total disability. And, I so find.

Finally, claimant must also establish that his total disability is due to pneumoconiosis. 20 C.F.R. § 718.204(b). To satisfy this requirement, the United States Court of Appeals for the Sixth Circuit requires a claimant to prove that his totally disabling respiratory impairment is due "at least in part" to his pneumoconiosis. *Adams v. Director, OWCP*, 886 F.2d 818, 825 (6th Cir. 1989).

Of the eight narrative opinions of record, six address the etiology of Claimant's pulmonary impairment. The April 13, 1999 report of Dr. Dahhan and Dr. Westerfield's report do not address whether Claimant's disability was caused by pneumoconiosis. Of the remaining six opinions, four physicians opine that Claimant's disability was not caused by pneumoconiosis, whereas two physicians conclude that pneumoconiosis caused, in part, Claimant's disability. Each opinion, and the probative weight I accord it, shall be discussed individually.

Dr. Dahhan opined that Claimant's pulmonary impairment was not caused by pneumoconiosis. The doctor based his opinion on the waxing and waning he identified in his independent medical review of various pulmonary function tests of the claimant. Dr. Dahhan stated that such waxing and waning was not consistent with the physiological effects of pneumoconiosis. In addition, the doctor cited Claimant's positive response to bronchodilator therapy as evidence that Claimant's pulmonary impairment was not caused by pneumoconiosis. The doctor stated that impairments such as Claimant's were consistent with bronchial asthma and hyperactive airway disease, but he did not state whether Claimant suffered from those conditions. Although the doctor's opinion is reasonable, I must grant it little probative value. As the doctor did not conclude that Claimant suffered from pneumoconiosis, his opinion whether the claimant's impairment was caused by pneumoconiosis is less probative. *See Toler v. Eastern Assoc. Coal Co.*, 43 F.3d 109 (4th Cir. 1995)(holding that where administrative law judge determines that miner suffers from pneumoconiosis or is totally disabled or both, then medical opinion wherein the miner is determined not to suffer from pneumoconiosis or is not totally disabled can carry little weight in assessing the etiology of the miner's total disability). In my review of the doctor's opinion on the etiology of Claimant's disability, I cannot locate a rationale that does not rest upon his disagreement with the ultimate factual findings of pneumoconiosis or total disability. Accordingly, I grant Dr. Dahhan's opinion little weight.

Likewise, Dr. Jarboe failed to diagnose pneumoconiosis, and, thus, his opinion regarding the etiology of Claimant's impairment carries little weight. The doctor attributed Claimant's impairment to bronchial asthma and smoking, stating that Claimant was totally disabled from a "long-standing, severe bronchial asthma and a past history of smoking cigarettes." (DX 35). Dr. Jarboe ruled out pneumoconiosis because Claimant's pulmonary function tests exhibited no restrictive defect and repeated measurements of the claimant's total lung capacity exhibited normal values.

Dr. Vaezy attributed Claimant's disability, in part, to pneumoconiosis. The doctor also opined that Claimant's smoking history impacted his impairment. I find the doctor's opinion probative because it provides a reasonable conclusion from documented results, but I grant the doctor's opinion less weight due to his failure to differentiate, if possible, the effects of smoking and coal mine employment. The doctor's report makes no effort to explain how both Claimant's smoking and coal mine employment contributed to his impairment beyond simply stating that both contributed. For that reason, I grant the opinion less weight, although I find it overall deserving of more than a modicum of probative weight.

Dr. Baker opined that Claimant's impairment was produced by coal dust exposure, smoking, and "possible" bronchial asthma. Like my analysis of Dr. Vaezy's opinion, I find Dr. Baker's opinion probative as it provides a reasonable medical conclusion from documented medical findings. I grant it less weight, however, as it too fails to differentiate from the effects of smoking and coal dust exposure, nor does the opinion explain how the doctor has identified the impact of smoking and coal dust exposure separately. Furthermore, the doctor's opinion that bronchial asthma possibly impacted Claimant's impairment level adds a veneer of equivocalness to the doctor's opinion that subtracts from its overall probative value.

Dr. Vuskovich opined that Claimant suffered from pneumoconiosis, but the doctor concluded that pneumoconiosis did not contribute to Claimant's impairment. Dr. Vuskovich based his opinion on the etiology of Claimant's impairment on the lack of any restrictive impairment in the objective test results. Although the doctor relied on an invalid pulmonary function test, his medical conclusions regarding the etiology of Claimant's impairment are reasonable and entitled to some probative weight. *See Cornett v. Benham Coal, Inc.*, 227 F.3d 569 (6th Cir. 2000)(holding it is inappropriate to reject physician's opinion which is based upon non-qualifying pulmonary function study values as the regulations explicitly provide that doctor can make reasoned medical judgment that miner is totally disabled even where pulmonary function tests and/or blood-gas studies are medically contraindicated). I grant the doctor's opinion less weight, however, because, beyond opining that pneumoconiosis did not cause Claimant's impairment, Dr. Vuskovich fails to provide an answer as to what did cause Claimant's impairment. Furthermore, the doctor's opinion does not address the impact of Claimant's twenty-year smoking history, as recorded by the doctor. These omissions render the doctor's opinion on the etiology of Claimant's impairment incomplete and less probative. Accordingly, I grant the opinion less weight.

Dr. Wicker opined that Claimant did not suffer from pneumoconiosis and that the etiology of his impairment was "previous cigarette abuse." (DX 11). As the doctor did not conclude that Claimant suffered from pneumoconiosis, his opinion whether the claimant's impairment was caused by pneumoconiosis carries little weight. *Toler*, 43 F.3d at 109. In addition, the doctor's diagnosis of the etiology of Claimant's impairment is poorly reasoned. Dr. Wicker fails to provide an explanation of his conclusions.

After an analysis of the six opinions addressing the etiology of Claimant's pulmonary impairment, I find that three opinions – the opinions of Drs. Dahhan, Jarboe, and Wicker – are entitled to little probative weight because each failed to make the preliminary positive finding of pneumoconiosis. Of the remaining three opinions, the two opinions finding pneumoconiosis caused, in part, Claimant's impairment – the opinions of Drs. Vaezy and Baker – received less weight due to flaws in their reasoning that subtracted from the overall probative value of the respective opinions. The lone opinion diagnosing pneumoconiosis but concluding that Claimant's impairment was not caused by the disease – the opinion of Dr. Vuskovich – received less probative weight due to a poorly reasoned opinion.

In sum, I find that Claimant has demonstrated that pneumoconiosis caused, in part, his total disability. The limited probative value of the opinions of Drs. Vaezy and Baker outweighs the limited probative value of Dr. Vuskovich's opinion, and, thus, the preponderance of the evidence weighs in favor of my finding that Claimant's pneumoconiosis caused, in part, his total disability.

Date of Entitlement

In the case of a miner who is totally disabled due to pneumoconiosis, benefits commence with the month of onset of total disability. Where the evidence does not establish the month of onset of total disability, benefits begin with the month that claimant filed his claim or requested modification. 20 C.F.R. § 725.503(b). *See Eifler v. Director, OWCP*, 926 F.2d 663, 666 (7th Cir. 1991); *Rochester & Pittsburgh Coal Co. v. Director, OWCP*, 868 F.2d 600, 603 (3d Cir. 1989); *Lykins v. Director, OWCP*, 12 BLR 1-181, 1-183 (1989). Based upon my review of the record, I cannot determine the month that claimant became totally disabled. As noted above, I have found no mistake in fact in the prior denial. Because Mr. Howard established modification based on a change in conditions, he shall receive benefits commencing August 2000, the month that he filed his request for modification.

Conclusion

In sum, I find that claimant has established the existence of pneumoconiosis arising from coal mine employment pursuant to 20 C.F.R. §§718.202(a)(4), 718.203(b). I also find that

claimant is totally disabled due to pneumoconiosis within the meaning of Section 718.204(b) and (c). Accordingly, Harold Wayne Howard is entitled to benefits.

Attorney's Fee

Claimant's counsel has thirty days to submit an application for an attorney's fee. The application shall be prepared in strict accordance with 20 C.F.R. §§ 725.365 and 725.366. The application must be served on all parties, including the claimant, and proof of service must be filed with the application. The parties are allowed thirty days following service of the application to file objections to the fee application.

ORDER

The Employer is hereby ORDERED to pay the following:

1. To claimant, Harold Wayne Howard, all benefits to which he is entitled under the Act, augmented by his reason of his one dependent, commencing August 2000;

2. To claimant, all medical and hospitalization benefits to which he is entitled, commencing August 2000;

3. To the Secretary of Labor, reimbursement for any payment the Secretary has made to claimant under the Act. The employer may reduce such amounts, as appropriate, from the amounts the employer is ordered to pay under paragraph 1 above; and,

4. To the Secretary of Labor or to claimant, as appropriate, interest computed in accordance with the provisions of the Act or regulations.

A

JOSEPH E. KANE
Administrative Law Judge

NOTICE OF APPEAL RIGHTS: Pursuant to 20 C.F.R. § 725.481, any party dissatisfied with this Decision and Order may appeal it to the Benefits Review Board within thirty days from the date of this decision by filing a Notice of Appeal with the Benefits Review Board at P.O. Box 37601, Washington D.C. 20013-7601. This decision shall be final thirty days after the filing of this decision with the district director unless appeal proceedings are instituted. 20 C.F.R.

§ 725.479. A copy of this Notice of Appeal must also be served on Donald S. Shire, Associate Solicitor for Black Lung Benefits, 200 Constitution Avenue, N.W., Room N-2117, Washington, D.C. 20210.